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ABSTRACT

Previous research on the relationship between workplace stressors and physical health symptoms in men has generated such important insights as the importance of job demand or overload to physical health. However, research on women, work and health raises several necessary additions to the paradigm: (1) a focus on the positive aspects of the workplace; (2) possible gender differences in the model; and (3) attention to the impact of family roles. This paper addresses these considerations using data from a disproportionate random sample of 403 employed women ages 25 to 55. Subjects were interviewed in their homes or offices about their major social roles, psychological distress, well being, and physical health. The results indicate that work rewards as well as work concerns are related to physical health symptoms; helping others at work is an important work reward for this sample which has not been identified in men; for employed mothers, satisfaction with salary is directly related to physical symptoms; and for women in troubled marriages or relationships, deriving reward from helping others at work reduces the impact of relationship problems on physical health. It is important to recognize that men and women operate in the worlds of work and home and that these two worlds affect each other. (Author/ABL)

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Physical Symptoms and the Interplay of Work and Family Roles

ABSTRACT

Previous research on the relationship between workplace stressors and physical-health symptoms in men has generated such important insights as the importance of job demand or overload to physical health. However, research on women, work and health raises several necessary additions to the paradigm, including : (1) a focus on the positive aspects of the workplace; (2) possible gender differences in the model; and (3) attention to the impact of family roles. In this paper we address these considerations using data from a disproportionate random sample of 403 employed women ages 25 to 55. The major findings are: work rewards as well as work concerns are related to physical health symptoms; helping others at work is an important work reward for this sample of women that had not been identified in samples of men; for employed mothers, satisfaction with salary is directly related to physical symptoms; and, for women in troubled marriages or relationships, deriving reward from helping others at work reduces the impact of relationship problems on physical health.

Main-stream research in behavioral medicine has focused heavily on the relationship between workplace stressors and symptoms in male populations. The thrust of the research has been to identify job conditions that are consistently associated with physical-health symptoms. This work has generated such important insights as the centrality of the role of overload (demand) in the genesis of physical-health problems (Haynes; Karasek;). However, research on women, work and health points to several important considerations which need to be incorporated into this paradigm if further progress is to be made. These include: (1) a focus on aspects of the workplace that are experienced as rewarding and that have direct and or moderating effects on the relationship between workplace stressors and symptom reports; (2) attention to possible gender differences in those aspects of the workplace that are experienced as problematic and as rewarding; and (3) attention to the impact of family roles (occupancy and quality) on the relationship between workplace rewards and concerns and physical-health symptoms. In this paper we address these considerations using data from a disproportionate random sample of 403 employed women ages 25 to 55.

Previous research suggests that work rewards as well as work concerns affect physical health. Particular work rewards, e.g., challenge, are reported to have direct effects on physical-health outcomes and certain work rewards, e.g., decision latitude, have been shown to condition the effect of work-place stressors on physical-health. Yet "stress research has concentrated on the presence of negative conditions ...and virtually has ignored stress reactions that result from the lack of positive conditions" (Pines & Kanner, 1982, p. 33).

Moreover, most researchers do not assess interactive effects (Karasek, Theorell, Schwartz, Schnall, Pieper, Michela, 1988). Even when interactions are estimated, the findings have not been conclusive (LaCroix & Haynes, 1987; Landsbergis, 1988). For example, Landsbergis (1988) failed to find interaction effects of decision latitude and demands in a study of female nurses. This finding may not be surprising given Karasek's observations that:

> although psychological demands at work do not differ markedly for men and women ... [there is] a substantially greater (negative) correlation between decision latitude and demands for women. The majority of women's high demand jobs also have low decision latitude, whereas large numbers of high demand jobs have high decision latitude for men. This implies a much higher proportion of high strain jobs ... among occupations where women predominate" (Karasek, Schwartz, Theorell, Pieper, Russell & Michela, 1982, pp. 49-50).

These speculations raise the possibility that work rewards other than decision latitude may be important for women.

To date, the search for work-stress moderators has been limited largely to decision latitude and social support at work. These limitations appear to derive as much from the constraints imposed by the availability of data (especially the Quality of Employment Survey (QES) data on which many analyses are based) as from any theoretical necessity. Moreover, these limitations may restrict our understanding of women's work experiences more strongly than those of men, since the original sample for the QES surveys were predominantly male.

With respect to women's family-role occupancy, previous research has focused on main not interactive effects. The basic finding is that among

employed women, partnered and married women report better physical health than do single women. There is some disagreement about the health consequences of parenthood among employed married women. Some researchers report the physical- health benefit enjoyed by employed married women is not affected by their parental status (Verbrugge, 1985), others report that a child in the home is associated with lowered risk among employed married women (Kotler & Wingard, 1989).

In spite of this disparity, there is agreement that the differential effect of parental status on physical health is low compared to that of employment and partnership status. The question of interest for this paper concerns the interactive effects of family-role occupancy on the relationship between work rewards and concerns and physical health reports. The only study to examine the interactive effects of marital and parental status on the relationship of work conditions to physical health found that risk of Coronary Heart Disease among employed clerical workers was substantially increased if they were married and had 3 or more children (Haynes & Feinleib, 1982). The sample for this study was stratified on partnership and parental status, enabling us to estimate separately the main and interactive effects of partner-role and parent-role occupancy on the relationship between workplace stressors and physical health symptoms.

Finally, almost no attention has been paid to the main or interactive effects of family-role <u>quality</u> on the relationship between workplace stressors and stress mitigators and physical health[1]. Yet it seems reasonable to expect that women who report positive experiences in their family roles will experience fewer physical symptoms than women with troubled relationships.

The important question for this paper is, does the quality of a woman's relationships at home affect her vulnerability or resilience to the negative-health effects of stressors at work and vice versa? More specifically, are there positive- or negative-spillover effects from home to work or from work to home?

Popular views of employed women portray them as under high strain as a result of combining demanding work and family roles. This line of thought implies negative-spillover effects from home to work and from work to home, so that women with demanding work and family roles will report poorer health. The notion of positive-spillover effects has received much less popular treatment and essentially no research attention. We examined both negative- and positive-spillover effects from home to work and from work to home.

Methods

Sample

The data for these analyses come from the first year of a three-year longitudinal study of a disproportionate, stratified, random sample of 403 women employed in one of two health care professions -- licensed practical nursing and social work. These two professions were selected on the basis of three criteria: (1) they are female professions; (2) they are high-strain professions; and (3) they are professions with public licensure records, thereby facilitating identification of populations from which to draw a sample.

Within the two occupations, the sample was stratified on race, parental status, and partnership status (women who were either married or living with a partner were defined as "partnered"). Sixty-one women (15.3%) were black, and 342 (84.7%) were white. Approximately half of the sample was partnered

(n=198, 49.1%) and roughly half had children (n=229, 56.8%). About half of the women with children were also partnered (n=123, 53.7% of all mothers); the others were single mothers. The respondent's children ranged in age from less than one year to over 30 years old. However, most of the mothers were not caring for young children; only 13.9% had a child under age six. In contrast, 45% of the mothers had children 18 years old or older.

The mean age of the respondents was 39.5 years (sd = 7.4). On average, they had been working in their respective fields for 11 years (the range was 2 to 35 years) and at their current jobs for six years. The sample was restricted to women employed at least 20 hours a week; they worked 38 hours per week on average, and 80% worked the same schedule on a regular basis. The mean individual income in 1985 was $24,400 (sd = $2,700).

All the respondents lived within a 25-mile radius of Boston. Respondents were interviewed in their homes or offices by a trained interviewer. The interviews lasted about 2 hours and covered each woman's major social roles, i.e., employee, mother, partner, as well as indices of psychological distress, well-being, and physical health. Respondents were paid a fee of $10 for participating. Only 4% of the eligible subjects whom we contacted, refused to participate.

Measures

Role-quality. The quality of the roles of worker and mother was assessed by rewards and concerns scales constructed originally from data gathered during in-depth interviews with 72 women, ages 35 to 55 (See Baruch & Barnett, 1986 for a full discussion).

For each role, subjects are instructed to think about their situation as it is right now and to indicate on a 4-point scale (1 = not at all to 4 =

extremely) to what extent, if at all, each of the items is rewarding (or of concern). (The number of items varied for each role; for the role of worker, there were 25 reward and 25 concern items; for the role of parent, there were 18-reward and 20-concern items; for the role of partner, there were 18 reward and 15 concern items.) To illustrate, for the role of paid worker, each employed subject was asked how rewarding she found "the job security" and to what extent "the job's not using your skills" was a concern. For the role of mother, each woman with children was asked how rewarding she found "the love they show" and how much of a concern was "how they spend their free time". For the role of partner, each partnered woman was asked, how rewarding she found "good communication" and how much of a concern was "arguing or fighting". Each subject received two scores for each social role: a reward score and a concern score. Role quality was operationalized as the difference between the reward and the concern scores (see Baruch & Barnett, 1986).

Test-retest reliability coefficients, calculated on a 10% random subsample reinterviewed within 1-3 months of the wave 1 interview, was .88 for both work rewards and work concerns, .82 for parent rewards and .70 for parent concerns, .87 for partner rewards and .78 for partner concerns. Cronbach alpha for work rewards was .88; for work concerns, it was .89; for parent rewards, .83 ; for parent concerns, .89; for partner rewards, .93 ; for partner concerns, .88.

Physical symptoms. Our measure of physical symptoms was a 29 - item measure of general physical symptoms. Respondents were asked to indicate both how frequently in the past year they had had each of these symptoms (1=never or almost never to 7= daily) and the degree of discomfort (from 1=no discomfort to 4=extreme discomfort) caused by the symptom in the past year. By multiplying the frequency of occurrence by the degree of discomfort for

each symptom and then dividing the product by 29, we derived a total score for physical symptoms that reflects the average frequency and discomfort per symptom. This score was then multiplied by 10 for the scale score. The 29-item scale was derived from measures developed by the Mind-Body Program at the Beth Israel Hospital, in consultation with Jane Lesser, an affiliate of that program.

Theoretically scores on the physical-symptom scale could range from 10 to 280. The actual range was from 10 to 84, with a mean of 26.3 (sd = 12.67). Of the 29 physical symptoms on the symptom checklist, fatigue/exhaustion was the most common. It was considered a problem by 86% of the women interviewed, although only 14% reported considerable or extreme discomfort from it. Other frequently-noted symptoms were headaches (79%), trouble sleeping (64%), stomach discomfort (62%), and back pain (61%).

Results

Preliminary analyses comparing the two occupational groups indicated no significant differences on any of the reward or concern scales. Using a dummy variable for occupation, a series of regression models was estimated to test for main and interactive effects of occupation on physical symptoms. The main effect of occupation and the interactions between occupation and race, age, and per capita income were non-significant. The two occupational groups were, therefore, combined for the analyses reported in this paper.

Specific Work Rewards and Concerns

To identify individual components of work, rewards and concerns, the sample was first divided into random halves. Exploratory work, guided by previous

research, was conducted on the responses of one half of the sample to the 25 empirically developed work-reward and the 25 work-concern items[2]. Confirmatory factor analyses were then performed on the responses of the other half of the sample.

Six work-reward factors were identified in one half of the sample and confirmed in the other half[3], namely: helping others at work, decision authority[4], challenge, supervisor support, recognition, and satisfaction with salary. Five work-concern factors were identified and confirmed: overload, dead-end job, hazard exposure, poor supervision, and discrimination.

The Relationship Between Work Rewards and Concerns and Physical Health

To identify those work reward and concern factors that have physical-health consequences, we estimated regression models with the physical-health measure as the outcome and the six reward factors entered simultaneously as predictors. We then estimated a regression model with the five work-concern factors entered simultaneously as predictors. In order to control for the relationship between background characteristics and the physical-health measure, all models included the following control variables: socioeconomic status[5], age, race and per capita income[6].

Of the six work-reward factors, only helping others and satisfaction with salary were significantly associated with physical symptoms, when all six were entered into the same regression equation. When we entered all 5 work-concern factors into one regression equation only two factors, hazard exposure and overload, emerged as significant. The items comprising these four factors are presented in Table One. Clearly, after controlling for other factors, some

the presence or absence of **both** work rewards and work concerns.

Insert Table Two about here

Having identified the work factors that have main effects, we addressed the question of moderating effects. (For this paper we have focused on moderators of overload. Future work will address moderators of hazard exposure.) Does the presence of particular work rewards mitigate the negative effect of particular work stressors? We examined the potential buffering effects of each of the 6 work-reward factors on overload in separate regression models.

Helping others at work was the most consistent work-reward factor that buffered the effects of overload. The helping others x overload interaction was significant ($B = -3.465$, $p < .01$)[7], and is presented graphically in Figure One. Under conditions of high rewards from helping others[8], employed

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Insert Figure One about here

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women with high concerns about overload at work report no more physical-health symptoms than employed women with low overload. Conversely, under conditions of both low rewards from helping others and high overload, reports of symptoms are especially high.

Thus, work overload, hazard exposure, satisfaction with salary, and helping others are strong predictors of physical-health symptoms. Moreover, rewards from helping others at work mitigate the negative effects of overload. To paraphrase a sentiment frequently expressed by our subjects, "The hassles at work are more tolerable if I can have an impact on someone's life."

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Does Women's Family-Role Occupancy Affect the Above Relationships?

Partner-role occupancy. As can be seen in Table Three, after taking into account, age, race, socioeconomic status and per capita income,

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Insert Table Three about here

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the main effect of partnership status is nonsignificant. Thus, employed single women are at no higher risk of physical symptoms than are employed partnered women, after the effects of age, race, SES and per capita income are taken into account. Additional analyses, not shown in Table Three, estimating the interactive effects of partnership status and each of the work reward and work-concern factors, yielded nonsignificant findings. In other words, the relationships between physical symptoms and the work-reward and work-concern factors were unaffected by the women's partnership status.

Parental status. While parent-role status had no direct effect on physical symptoms, after controlling for the effects of age, race, SES, and per capita income, parent-role status had a significant interactive effect on the relationship between physical-health reports and satisfaction with salary. Inclusion of the parent-role occupancy X satisfaction with salary interaction resulted in an increment to R^2 significant at $p < .001$. (See Table Four.)

Insert Table Four about here

Physical-symptom reports among employed mothers are inversely related to satisfaction with salary, whereas they are unrelated to satisfaction with salary among employed women who are not mothers. (See Figure Two.)

Insert Figure Two about here

Moreover, the interaction between satisfaction with salary and parental status occurred for both single and partnered women. It appears that the impact of stress associated with low levels of rewards from salary is felt more strongly among women who have the financial strain of rearing children, whether they have a partner or not.

How Does the Quality of Women's Family Roles Affect these Relationships?

To estimate the effects of family-role quality, we restricted the analyses to women occupying the relevant role. Thus, the samples for the separate regression models differed; the regression model estimating the effect of partner-role quality was calculated for the partnered women (n = 188 with non-missing data); the model estimating the effect of parent-role quality was computed on the subsample of mothers (n = 211 with non-missing data). The data are presented in Table Five. As expected, even after taking into account work rewards and work concerns, women who report rewarding relationships with partners or children also report low-levels of physical symptoms[9].

Insert Table Five about here

Contrary to widely-held assumptions, we found no evidence of negative-spillover effects. That is, the relationship between physical symptoms and high concerns about overload at work was not compounded by problems at home, neither was the relationship between physical symptoms and problems at home made worse by concerns about overload.

In contrast, we found positive-spillover effects from work to home for partnered women. Employed partnered women who experience high levels of reward from helping others at work are protected from the negative effects of troubled relationships with their partners (unstandardized regression coefficient for partner concerns x helping others at work was $B = 11.33$, $p < .001$), as shown in Figure Three.

Insert Figure Three about here

Employed women in troubled marriages are more reactive to the presence or absence of rewards from helping others at work. Women in good marriages, in contrast, are less reactive to the presence or absence of this reward.

Discussion and Conclusions

The major findings of this study are: work rewards as well as work concerns need to be assessed in any attempt to understand the relationship between work conditions and physical health; there may be gender differences in the aspects of work that are experienced as rewarding or that moderate the negative effects of work overload; and family roles (quality as well as occupancy) must be assessed for their main and interactive effects on these relationships.

A focus on work concerns (i.e, stressors) is inadequate for understanding the workplace stress-illness relationship, since physical health reports are as much affected by the absence of work rewards as by the presence of work concerns. Rewards from helping others at work and from satisfaction with salary were associated with low levels of physical complaints. Moreover, work rewards may have moderating effects on overload at work, which appears to be the most

consistent source of physical-health (and mental-health) related problems. In particular, helping others at work emerged in these analyses, as well as those with mental-health indicators as the outcome (Barnett & Marshall, forthcoming), both as the work-reward factor most consistently and strongly predictive of health outcomes in this sample and as a moderator of the negative effects of workplace overload. Employed women who experience high rewards from helping others at work report low levels of physical complaints and are resilient to the negative health effects of overload.

These findings offer only modest support for Karasek's job demand x job control interaction model. Whereas overload (i.e., demand) emerges as one of the job stressors most consistently related to physical-health symptoms, decision latitude, which is measured by our work-reward factors of challenge and decision authority, had neither main nor interactive effects on physical symptoms after considering the importance of other work factors. This important difference may be due to the inclusion of the helping-others factor, which has not been part of any male-based models of work rewards or job-stress mitigators. Given that women's jobs overall tend to be low in control compared to men's jobs, the reward of helping others at work may function for women in the way that job control functions for men.

We are not yet able to say whether helping others at work is a reward specific to employed women, to people (men and women) in health-care occupations, or both. Future work will provide answers to this question.

The significant interactions between women's family-role occupancy and quality and particular work factors underscores the need to incorporate into the mainstream research paradigm variables reflecting the non-workplace lives of female as well as male employees. To illustrate, the greater reactivity of employed women with children to the presence or absence of rewards from

satisfaction with salary probably reflects the greater financial burden of having dependent children, perhaps especially teen-age and college-age children. It is, of course, likely that employed men with children also feel this burden. However, no research that we are aware of has examined the effects of either partnership or parental status on the relationship between work-place factors and physical- health problems among men. Indeed, most main-stream research on men and work doesn't even report family-role status, and even when it does, it uses the data only as a control.

Further, the quality of an employed woman's relationship with her partner conditioned the physical-health benefit she derived from helping others at work. The physical-health complaints of employed women with troubled relationships (compared to those with good relationships) were more sensitive to the presence or absence of this reward. As noted above, the possibility that rewards from work could offset the negative effects of home-based woes has received scant attention. Again, it is reasonable to assume that the quality of men's family roles may also moderate the impact of work-related rewards and concerns.

Also attesting to the complex interplay between work-role and family-role quality is the absence of negative-spillover effects. These findings suggests that employed women leave their home-based woes behind when they arrive at work and do not allow their work-related woes to undo the gains they reap from positive relationships at home. Thus,it appears that employed women compartmentalize their subjective experiences at home and at work to a much greater extent than notions of "permeability" suggest. To further support this conclusion, analyses with mental-health indicators as outcomes also found no evidence of negative-spillover effects between the quality of women's work and family roles (Barnett & Marshall, forthcoming).

It is important to recognize that men and women operate in the worlds of work and home and that these two worlds affect each other. Future research on men and stress needs to place men in the context of their family roles and to examine the interplay between these two worlds.

References

Barnett, R.C., & Marshall, N.L., (forthcoming). The relationship between women's work and family roles and subjective well-being and psychological distress. In M. Frankenhauser, M. Chesney, & U. Lundberg (Eds.), Women, Work and Health. Chicago: University of Chicago Press.

Haynes, S. G., & Feinleib, M. (1982). Women, work and coronary heart disease: Results from the Framingham 10-year follow-up study. In P. Berman & E. Ramey (Eds.), Women: A developmental perspective (NIH Publication No. 82-2298). Washington, D.C.:U.S. Government Printing Office.

Karasek, R. A., Schwarts, J., Theorell, T., Piper, C., Russell, B.S., & Michela, J. (1982). Final Report: Job Characteristics, occupation and coronary heart disease. New York: Columbia University, Department of Industrial Engineering and Operations Research.

Kotler, P., & Wingard, D.L. (1989), The effect of occupational, marital and parental roles on mortality: The Alameda County Study. American Journal of Public Health, 79, 607 - 611.

Verbrugge, L. M. (1987). Role responsibilities, role burdens, and physical health. In Faye J. Crosby (ed.), Spouse, parent, worker: On gender and multiple roles. New Haven: Yale University Press.

Verbrugge, L. M., & Madans, J.H. (1985). Social roles and health trends of American women. Milbank Memorial Fund Quarterly/ Health and Society, 63, 691-735.

Footnotes

1. Verbrugge (1987) demonstrated that subjective experience of life roles (particularly the employee or homemaker role) had greater predictive value for physical health than did more objective aspects of roles (1987).

2. The work-reward and work-concern scales are available upon request from the authors.

3. See Barnett & Marshall (in preparation) for a full discussion of the factor analytic procedures and outcomes.

4. The term decision authority is used because the items comprising this factor correspond closely to those identified by Karasek et al. (1982), who also uses this term. The four items comprising Karasek's decision authority scale are: (1) freedom as to how I work; (2) allows a lot of decisions; (3) assist in one's own decision; and (4) have say over what happens.

5. Socioeconomic status was determined by summing scores for occupation (2 = social worker, 1 = licensed practical nurse) and years of education. This model of SES was based on results from a principle components analysis indicating that these two variables contributed equally to the first component.

6. Since roughly 30 women did not provide per capita income data, the number of subjects in the following regressions is less than 403.

7. The addition of the interaction term to the regression model resulted in an increase in R^2 that was significant at $p < .001$.

8. High and low are defined as plus/minus one standard deviation.

9. Perhaps because of the smaller sample size in these analyses, the main effects for the four work-reward and work-concern factors are not consistently significant.

Table 1

Items Comprising Significant Work-Reward and Work-Concern Factors

Work-Reward Factors	Item
Helping Others at Work	Helping others
	Being needed by others
	Having an impact on other people's lives
Satisfaction with Salary	The income
	Making good money compared to other people in your field

Work-Concern Factors	Item
Overload	Having too much to do
	The job's taking too much out of you
	Having to deal with emotionally difficult situations
Hazard Exposure	Being exposed to illness or injury
	The physical conditions of your job (noise, crowding, temperature, etc.)
	The job's taking too much out of you

Table 2

Work-Reward Factors, Work-Concern Factors, and Physical Health

Work Factors	B[a]	SE[b]
Helping Others at Work	-3.24**	1.12
Satisfaction with Salary	-2.17**	.80
Overload	1.75*	.91
Hazard Exposure	4.28***	1.03

R^2 = 17

Note. N = 371

a Unstandardized regression coefficients.

b Standard error.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 3

Work-Reward Factors, Work-Concern Factors, Partner-Role Occupancy and Physical Health

Predictor	B[a]	SE[b]
Helping Others	-3.20**	1.11
Satisfaction with Salary	-1.95*	.80
Overload	1.62	.90
Hazard Exposure	4.27***	1.02
Overload X Helping Others	-3.07*	1.34
Partner-role occupancy	-.78	1.22

R^2 = .18

Note. N = 371

a Unstandardized regression coefficients

b Standard error

* p < .05; ** p < .01; *** p < .001.

Table 4

Work-Reward Factors, Work-Concern Factors, Parent-Role Occupancy and Physical Health

Predictor	B[a]	SE[b]
Helping Others	-3.04**	1.11
Satisfaction with Salary	-1.87*	.79
Overload	1.69	.90
Hazard Exposure	4.41***	1.01
Overload X Helping Others	-3.45*	1.32
Parent-role occupancy	-.40	1.64
Parent-role occupancy X Satisfaction with Salary	-4.72**	1.59

R^2 = .20

Note. N = 371

a Unstandardized regression coefficients

b Standard error

* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 5

Work-Reward Factors, Work-Concern Factors, Family-Role Quality and Physical Health

	Partner-Role Quality [a]		Parent-Role Quality [b]	
Predictors	B[c]	SE[d]	B[c]	SE[d]
Helping Others	-1.26	1.50	-2.43	1.67
Satisfaction with Salary	-2.31*	1.07	-3.70***	1.06
Overload	2.50*	1.18	1.93	1.32
Hazard Exposure	3.34*	1.40	3.87**	1.44
Partner-role quality	-2.18*	-2.46		
Parent-role quality			-2.30*	1.01
R^2	.22		.23	

a n = 188

b n = 211

c Unstandarized regression coefficients

d Standard Error

* $p < .05$; ** $p < .01$; *** $p < .001$.